WEST (Jas. N.)

A successful secondary laparotomy for hæmorrhage

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A SUCCESSFUL SECONDARY LAPAROTOMY FOR HÆMORRHAGE FOLLOWING ABDOMINAL HYSTERECTOMY.*

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The chief interest of this case centers about the fact of its being a successful secondary operation for hæmorrhage following hysterectomy.

A brief detail of the conditions leading up to the operation will be given.

Mrs. I. R., admitted to the Woman's Hospital July 27, 1895. Age, thirty-two years; married seven years; two children, ages four and five years, and one abortion, six months before entrance to hospital, at four months.

The last child was delivered with instruments.

Menstruation was regular every twenty-eight days; duration five to six days; quantity was not excessive.

During the periods there was a great sense of weight and bearing down in the pelvis, accompanied by considerable pain.

The patient had complained of her present symptoms for about two years, the chief of which were pain in the lumbo-sacral region and in the left side, and the menstrual symptoms mentioned above.

Examination by vagina showed a lacerated posterior wall and cervix, considerable prolapse of the anterior and posterior walls, with the cervix presenting almost at the ostium vaginæ.

The uterus was considerably and asymmetrically enlarged, the enlargement being upon the right side. The whole fundus felt smooth through the abdominal wall.

It was determined to do a series of plastic operations for the relief of procidentia.

* Read before the Woman's Hospital Society, January 14, 1896.

The first of the series, curetting followed by trachelorrhaphy, was done August 6th, for removal of the diseased tissue of the cervix and to promote involution of the uterus.

By the middle of September it was found that the uterus not only was not undergoing involution, but was becoming larger.

The pelvic symptoms were becoming more severe, the patient being in almost constant pain. It was then decided to do an exploratory laparotomy.

This operation was performed at 2 P. M. September 17th.

The right side of the uterus was the seat of an intramural fibroid about the size of a hen's egg. The right ovary was badly diseased and contained a small cyst; there was also a small parovarian cyst on the left side. These conditions decided me to perform a total ablation of the uterus and annexa.

The cervix was quite elongated, and in dissecting it from the bladder and rectum an unusually large number of small blood-vessels were encountered. The uterine and ovarian arteries were tied with silk ligatures, cut short, and the uterus, with tubes and ovaries attached, was removed. The space between the rectum and bladder was firmly packed with gauze, covering the pedicles in the broad ligaments except those of the ovarian arteries. The pelvic vault was closed by suturing the peritonæum of the broad ligaments and flaps from the front and rear of the uterus with catgut.

The patient was put to bed in excellent condition, having lost but a very small quantity of blood.

She continued to do well, apparently, until about 7 P. M., when the house surgeon was called by the nurse on account of the vulval dressing being saturated with blood. He elevated the foot of the bed, removed this external dressing, packed about ten yards of sterilized gauze into the vagina, and replaced a vulval pad. Half an hour later this fresh dressing was completely saturated as before.

I was then sent for. Upon arrival, the patient's pulse was 125, respirations rapid, pallor was marked. At about 8.30 the patient was taken to the operating room and the attempt was made to ascertain the source of the hæmorrhage. Failing in this, and the hæmorrhage being considerable, the patient was hastily prepared for secondary laparotomy. Anticipating the necessity for secondary operation, preparations were made before my arrival.

Upon reopening the abdomen and placing the patient in the Trendelenburg posture the pelvis was seen to be almost free from blood, except along the line of suture of the broad ligaments. Upon removing

the sutures, which united the pelvic peritonæum, extensive hæmorrhage was seen to proceed from numerous small vessels in the flaps dissected from the front and rear of the uterus. These were sutured over with catgut, and the posterior flap, from which considerable oozing was observed, was folded forward upon itself and quilted through with catgut.

All bleeding points having been secured, the space between the bladder and rectum was again packed with gauze and the pelvic peritonæum reunited with catgut. The vagina was then packed with gauze.

During the operation for control of the hæmorrhage, and near its completion, an injection of ten ounces of normal saline solution was made into the right median basilic vein.

During the course of the operation the pulse became almost imperceptible. About one drachm of brandy, one twentieth of a grain of strychnine, and fifteen minims of tincture of digitalis were hypodermically administered, and inhalations of oxygen were given.

The pulse showed no appreciable improvement until the intravenous injection, when marked improvement was observed.

The patient was put to bed and given a stimulating enema, containing two ounces of brandy in saline solution. The foot of the bed was elevated and the extremities were tightly bandaged. The inhalations of oxygen were continued for several hours. The improvement was slow but steady. Recovery was uninterrupted with the exception of a mural abscess and a slight cystitis.

The patient was discharged November 24, 1895, almost entirely relieved of all the disagreeable symptoms from which she had suffered.

Some points of interest to which this case calls my attention are the following:

1. That, within certain limits, the size is not so important an element in determining hysterectomy as the symptoms produced by and the location of a fibroid.

2. By closing the peritonæum and making all the ligatures extraperitoneal, any hæmorrhage which occurred found its way into the vagina, and was easily detected, the large quantity of blood lost determining the gravity of the situation rather than the ordinary symptoms of hæmorrhage, thus enabling us to operate before it was too late.

3. As a rule, when the usual and well-marked symptoms of hæmorrhage have occurred and have been recognized, it is too late to

operate successfully. The hæmorrhage and shock of the second operation will probably prove fatal.

4. When there is strong reason to believe that hæmorrhage is occurring it is absolutely the duty of the surgeon to proceed to radical measures for its control, and that his life-saving efforts are incomplete unless saline infusion has been employed.

5. It is very important that the quantity of saline infusion should not be excessive, from eight to fourteen ounces being sufficient in most cases. Larger quantities infused throw too much of a burden upon a heart the nutrition of which is impaired by the over-dilution of the blood.

6. Many of the cases which are supposed to die of shock die of hæmorrhage.

In conclusion, I should like to state that the successful termination of this case was due in a large measure to the assistance of a very efficient house staff.